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ATTACHMENT 4.19-B
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR STATE PLAN COVERED SERVICES

A. When services which are reimbursed per a fee schedule, unless otherwise noted below, the same fee schedule applies to all providers -- both public and private -- and the fee schedule is published at the Iowa Medicaid Agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule.

Except for Other Independent Laboratory services, physician assistant services anesthesia services, CRNAs, and pharmacy/pharmacists services, the agency's rates were set as of July 1, 2021, and are effective for services on or after that date.

The fee schedule amounts for Other Independent Laboratory services, including code series 81000 are based on 95% of the Medicare Clinical Laboratory Fee Schedule. Effective January 1, 2017, and thereafter, the Department shall update the Independent Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

The agency's rates were set as of December 1, 2020, for physician assistant services.

Effective July 1, 2017, the Department shall update the anesthesia conversion factor using the most current calendar year update of the Medicare anesthesia conversion factor, adjusted for the state as described below, converted to a per minute amount.

The agency's rates for CRNAs were set for services on and after December 1, 2020, and will be updated annually with the most recent Medicare anesthesia conversion factor as described above.

The agency's rates were set as of December 1, 2020, for pharmacy/pharmacists services.

B. The principles and standards established in OMB Circular A-87 are applied, when applicable, in determining rates regardless of the reimbursement methodology or fee schedule described below.

C. Rates paid for individual practitioner services based on the fee schedule or methodology described below shall not exceed the provider's customary charges for the service billed. In order for the Iowa Medicaid Agency to meet the requirements of 42 CFR 447.203(b)(1) providers of individual practitioner services must bill Medicaid the customary charge for the service provided.

D. Providers of services must accept reimbursement based upon the Iowa Medicaid agency fee or methodology without making any additional charge to the recipient.

E. All payments are made to providers. The term "provider" means an individual or an entity furnishing Medicaid services under an agreement with the Iowa Medicaid agency. An entity need not be a facility such as a hospital, ICF/ID, or nursing. Pursuant to 42 CFR 447.15 (g), the term may include facilities or entities who employ or contract with persons who are authorized under the Iowa State Plan to provide covered services. Also an entity may provides, for example, "clinic services (as defined in 42 CFR 440.90)" or "home health services (as defined in 42 CFR 440.70) and other services which are otherwise covered under Iowa Medicaid through its employees or contractors. In the latter case the entity would also be paid for those non-clinic and

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or non-home health services if it had an employment contract or other contract with the licensed health care professional providing those services which meets the requirements of 42 CFR 447.15(g).

F. Below is a description of the methods and standards for establishing rates for all covered services other than waiver services. The numbering and description of is identical to the list of covered services contained in ATTACHMENT 3.1-A. **(Continued on page 2 of Att. 4.19-B)**

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The following services will be modified:
Various services applicable to fees schedule language on page 1 (Physician Services; Podiatrist Services; Optometrist Services; Chiropractor Services; Audiology Services; Hearing Aide Dispenser Services; Psychologist Services; Services of Advanced Registered Nurse Practitioners; Services of Certified Nurse Anesthetists; Certain Pharmacists Services; Services of Advanced Nurse Practitioners Certified in Psychiatric or Mental Health Specialties; Renal Dialysis Clinics; Ambulatory Surgical Centers; Maternal Health Centers; Home Health-Medical Supplies and Equipment; Physical Therapy Services; Occupational Therapy Services; Services for Individuals with Speech, Hearing and Language Disorders; Prosthetic Devices; Eyeglasses; Nurse Midwife Services; Extended Services for Pregnant Women; Ambulatory Prenatal Care for Pregnant Women during a Presumptive Eligibility Period; Nurse Practitioner Services; Transportation Services) – Effective for services rendered on or after September 1, 2011, reimbursement will be 95% of the agency's rates set as of July 1, 2008, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 1 of Attachment 4.19-B)

Ambulance Services – Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 10%. Effective for services rendered on or after July 1, 2014, reimbursement rates will be increased by 10%. Effective for services rendered on or after July 1, 2021, air ambulance reimbursement rates will be increased by 219.59% (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered between December 1, 2009 and December 31, 2009, reimbursement will be made at 95% of Medicare's January 1, 2009, clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered on or after January 1, 2010, reimbursement will be 95% of Medicare's January 1, 2010, clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Various services applicable to fees schedule language on page 1 (Dental Services; Dentures; Medical and Surgical Services Furnished by a Dentist) – Effective for services rendered on or after December 1, 2009, reimbursement will be 97.5% of the agency's rates set as of July 1, 2008. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

Preventative Exam Codes rendered in connection to services provided by IowaCare network providers – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

EPSDT: Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 5 of Attachment 4.19-B)

Family Planning Services – Agency's rates were set as of July 1, 2008, and are effective for services rendered on or after that date. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

Existing IowaCare plan ended on December 31, 2013.

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Home Health-Intermittent Nursing Services – Effective for services rendered on or after December 1, 2009, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation. (Page 8 of Attachment 4.19-B)

Effective for services rendered on or after July 1, 2012, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at June 30, 2012, plus two percent; or the base year Medicare per visit limitations plus inflation (Page 8 of Attachment 4.19-B).

Community Mental Health Centers – Effective for services rendered December 1, 2009 through June 30, 2010, reimbursement will be reduced to 97.5% of reconciled cost. (Page 9, of Attachment 4.19-B)

Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 12 of Attachment 4.19-B)

Hospital-Specific Base APC Rates – Effective for services rendered on or after December 1, 2009, all reimbursement rates will be reduced by 5%, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 14 of Supplement 2 of Attachment 4.19-B)

Graduate Medical Education and Disproportionate Share Pool – Effective from December 1, 2009, the total annual pool amount that is allocated to the Graduate Medical education and disproportionate share pool for direct medical education related to outpatient services is $2,776,336. (Page 22 of Supplement 2 of Attachment 4.19-B).

Physician and Non-Physician Care Services Rendered in Facility Settings – Effective for services rendered on or after July 1, 2017, physician and non-physician care providers are subject to a site-of-service payment adjustment. A site of service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Iowa Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service. The Department shall update the Medicare differentials applied to the site-of-service payment adjustment every January 1, thereafter.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician and non-physician care services. The agency's rate was set as of July 1, 2017, and is effective for services provided on or after that date. All rates are published on the agency's website: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule.

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Physician-Administered Drugs – Effective for services rendered on or after September 1, 2012, reimbursement for HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999, will be reduced by 2%. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:
http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

limits on amount, duration and scope contained in SUPPLEMENT 2 TO ATTACHMENT 3.1-A.

1. INPATIENT HOSPITAL SERVICES
See Attachment 4.19 - A of the State Plan

2a. OUTPATIENT HOSPITAL SERVICES
See Supplement 2 to Attachment 4.19-B of the State Plan

2b. RURAL HEALTH CLINICS SERVICES

X The payment methodology for rural health clinics will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

___ The payment methodology for rural health clinics will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for rural health clinics will conform to BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the clinic: and
2) results in payment to the clinic of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement
The APM reimbursement methodology for rural health clinics is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement
The Department uses the clinic's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost. Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the rural health clinic. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate, which would be paid to participating rural health clinics under the prospective payment system considering any change in the scope of service applying all appropriate Medicare Economic Index increases. The Department will compute the center's FY 1999 and FY 2000 per visit rate for each clinic and will use an average of the two as the initial PPS base rate. This rate will be used to calculate the total

payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each clinic an encounter rate that is at least equal to the PPS rate specific to each clinic. The clinic must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Clinics

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

X The payment methodology for federally qualifying health centers will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

___ The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the center; and
2) results in payment to the center of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement

The APM reimbursement methodology for federally qualified health centers is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement

The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost.

Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the federally qualified health center. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate which would be paid to participating federally qualified health centers under the prospective payment system, considering any change in the scope of service and applying all appropriate Medicare Economic Index increases. This rate will be used to calculate the total payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each center an encounter rate that is at least equal to the PPS rate specific to each clinic. The center must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Centers

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

3. OTHER INDEPENDENT LABORATORIES SERVICES
Fee Schedule. The fee schedule is 95.00% of the Medicare Clinical Laboratory Fee Schedule.

4a. NURSING FACILITY SERVICES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES)
See Attachment 4.19-D of the State Plan.

4b. EARLY PERIODIC DIAGNOSTIC AND SCREENING SERVICES

(1) Outpatient Hospital Services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(2) Services of licensed practitioners of the healing arts: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(3) Private duty nursing services: For services on or after, July 1, 2013, payment for private duty nursing services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per hour. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.

(4) Home health services –medical supplies and equipment: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(5) Personal care services: For services on or after, July 1, 2013, payment for personal care services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per 15 minutes. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.

(6) Dental services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(7) Diagnostic services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(7a) Preventive Services: Fee Schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of July 1, 2014, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(8) Rehabilitative Services: For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using finalized cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov. Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

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(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

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For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

(9) Transportation services: Fee schedule.

Revised Submission 6.12.12

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(10) Personal care services: Same basis as home health services – home health aide described in Item 7b.

4c. FAMILY PLANNING SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

4d. TOBACCO CESSATION SERVICES
Fee Schedule. To maximize the effectiveness of tobacco cessation medications, counseling services are available for Medicaid member use in conjunction with cessation medication. Counseling services must be prescribed by a licensed practitioner participating in the Iowa Medicaid Program. Clinicians and other licensed practitioners must bill their usual and customary charges and must use the appropriate CPT codes to bill for counseling services.

5a. PHYSICIANS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

5b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6a. PODIATRISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6b. OPTOMETRISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6c. CHIROPRACTORS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d1. RESERVED

6d2. RESERVED

6d3. AUDIOLOGY SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d4. HEARING AID DISPENSER SERVICES
Fee schedule. The fee schedule is based on the definitions of medical and surgical supplies given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

6d5A. PSYCHOLOGISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d5B. SOCIAL WORKERS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The following are exceptions:

When social worker services are provided by a social worker employed by a physician, hospital, home health agency, rural health clinic, federally qualified health center or community mental health center, payment for the service will be made to the provider based upon a fee schedule for physician and community mental health center and the reimbursement defined for hospital, home health agency, rural health clinic and federally qualified health center services.

6d6 BEHAVIORAL HEALTH PROVIDERS
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The agency's rates were set as of December 1, 2008 and are effective for services on or after that date.

6d7 PHYSICIAN ASSISTANTS SERVICE

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures give in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee scheduled is established as 85% of the physician fee schedule.

6d8 A. SERVICES OF ADVANCED REGISTERED NURSE PRACTITIONERS
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

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6d8 B. SERVICES OF CERTIFIED NURSE ANESTHETISTS

Fee Schedule. Payment for CRNA services is made using the CMS fee schedule (CPT-4) anesthesiology procedure list and associated base units. When the CRNA receives medical direction from the surgeon, reimbursement to the CRNA is 80% of the amount that would be paid to an anesthesiologist (MD or DO). When the CRNA receives medical direction from an anesthesiologist, reimbursement to the CRNA is 60% of what an anesthesiologist would receive for the same procedure.

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6d9. PHARMACIST/PHARMACY SERVICES: Fee schedule.

6d10. SERVICES OF ADVANCED NURSE PRACTITIONERS CERTIFIED IN PSYCHIATRIC OR MENTAL HEALTH SPECIALTIES: Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

7. HOME HEALTH SERVICES – SKILLED NURSING SERVICES, HOME HEALTH AIDE SERVICES, PHYSICAL THERAPY SERVICES, OCCUPATIONAL THERAPY SERVICES & SPEECH PATHOLOGY SERVICES

Fee schedule. The payment for each home health service is determined by the Medicare low utilization payment adjustment (LUPA) wage index-adjusted fee schedule rates for each of the disciplines (skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), and speech therapy (ST). The LUPA base rates and the Medicare wage index shall be updated every two years.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health skilled nursing, home health aide, physical therapy, occupational therapy, and speech pathology services. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at:
http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

7a. HOME HEALTH SERVICES - MEDICAL SUPPLIES AND EQUIPMENT: Fee schedule.

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8. RESERVED

9. CLINIC SERVICES

Physician and dental fee schedules, except as follows:

(a). Clinics that are renal dialysis clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(b). Clinics that are ambulatory surgical centers are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(c). Clinics that are maternal health centers are paid for clinic services on a prospective cost-based fee schedule with no retroactive cost settlement, as determined by the Department based on a cost center report submitted by clinics on an annual basis. Services payable to the clinics include: 1) Maternal Health 2) Maternal Oral Health 3) Immunization 4) Laboratory. Cost of services to calculate the cost-based fee schedule rates includes direct cost (personnel and supplies) and overhead indirect cost incurred to support the services. Agency rates were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(d). Clinics that are family planning clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(e). **Payments to Indian Health Services and Tribal 638 Programs**

All-inclusive rates (AIR): The Medicaid all-inclusive rates (AIR) are published each year in the Federal Register by the Department of Health and Human Services, for general covered services provided by Indian Health Services (IHS) facilities and facilities operated by federally recognized tribes under P.L. 93-638.

The general covered service categories are: Inpatient; Outpatient, Pharmacy, Vision, Dental, Mental Health, Substance Use Disorder, Clinic and EPSDT.

Tribal 638 Federally Qualified Health Center (FQHC) Alternate Payment Methodology

A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM, which is the AIR. Tribal 638 FQHCs are not required to comply with the HRSA rules for a FQHC.

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Iowa Medicaid will establish a Prospective Payment System (PPS) methodology for Tribal 638 FQHCs. The PPS rate shall be the average rate of other FQHCs in the state. Annually, Iowa Medicaid will compare the APM rate to the PPS rates to ensure the APM is equal to or greater than the PPS rate. The Tribal 638 FQHCs are not required to report its costs for the purposes of establishing a PPS rate.

Multiple visits for different services on the same day with different diagnosis:
IHS facilities, Tribal 638 facilities, and Tribal 638 FQHCs are eligible for multiple encounter payments for general covered service categories on the same day for the same recipient with a different diagnosis. For services provided, these clinics may bill for one visit per patient per calendar day for covered outpatient prescribed drugs provided by the facility (at the outpatient prescribed drugs per visit rate (excluding Medicare)), which shall constitute payment in full for all services provided on that day.

Multiple visits for different services on the same day with the same diagnosis:
IHS facilities, Tribal 638 facilities, and Tribal FQHCs are eligible for multiple encounter payments for general covered service categories on the same day for the same recipient with the same diagnosis provided they are for distinctly different services. The diagnosis code may be the same for each of the encounters, but the services provided must be distinctly different and occur within different units of the facility.

Multiple visits for the same type of service on the same day with different diagnoses:
IHS facilities, Tribal 638 facilities, and Tribal 638 FQHCs are eligible for multiple encounter payments for multiple same day visits for the same type of general covered service category if the diagnoses are different.

(f). When a facility provides services, which are otherwise covered under the state plan, in addition to clinic services, payment is based on the methodology as defined for the service that is provided.

(g). Reimbursement methodology for Community Mental Health Centers:

Community Mental Health Centers may choose one of the following reimbursement methodologies:

1. Prospective statewide rate.

   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of

community mental health services. The agency's fee schedule rate was set as of July 1, 2014 and is effective for services provided on or after that date.

All rates are published on the agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

2. 100 percent of the reasonable costs of service.

This methodology will consist of a cost report and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Interim Payment

The Department makes interim payments to the Community Mental Health Center based upon 105% of the greater of the statewide fee schedule for Community Mental Health Centers effective July 1, 2006 or the average Medicaid managed care contracted fee amounts for Community Mental Health Centers effective July 1, 2006.

After cost reports are received, the Department will examine the cost data for Community Mental Health Center services to determine if an interim rate change is justified.

Determination of Medicaid-allowable direct and indirect costs

To determine the Medicaid-allowable direct and indirect costs of providing Community Mental Health Center services, the following steps are performed:

1. Direct costs for Community Mental Health Center services include unallocated payroll costs and other unallocated costs than can be directly assigned to Community Mental Health Center services. Direct payroll costs include total compensation of direct services personnel.

   Other direct costs include costs directly related to the approved Community Mental Health Center personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment.

   These direct costs are accumulated on the annual cost report, resulting in total direct costs.

2. General and Administrative indirect costs are determined based on the percentage of directly assigned Community Mental Health Center direct cost to Total cost before general and administrative overhead.
3. Net direct cost and general and administrative indirect costs are combined.
4. The combined costs from Item 3 are divided by total Community Mental Health Center units of service provided for all patients to calculate a cost per unit.
5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the total Medicaid units of service that were paid from the claims data.

Annual Cost Report Process

Community Mental Health Centers are required to submit a Medicaid cost report, per the Medicaid cost principles 2 CFR, Part 200, to the Department 90 days after their fiscal year for free-standing clinics and 120 days for hospital-based clinics. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Community Mental Health Center.

The primary purposes of the Medicaid cost report are to:

1. Document the provider's total Medicaid-allowable costs of delivering Medicaid coverable services.
2. Reconcile annual interim payments to its total Medicaid allowable-costs.

All filed annual Medicaid cost reports are subject to a desk review by the Department or its designee. Community Mental Health Centers must eliminate unallowable expenses from the cost report. If they are not removed the Department or its designee will make the appropriate adjustments to the Community Mental Health Center's Medicaid cost report.

Cost Reconciliation Process

The cost reconciliation must be completed by the Department or its designee within twenty-four (24) months of the end of the cost reporting period covered by the annual Medicaid cost report. The total Medicaid-allowable costs are compared to interim payments received

by the Community Mental Health Center for services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

Cost Settlement Process

EXAMPLE: For services delivered for the period January 1, 2010, through December 31, 2010, the annual Medicaid cost report is due on or before March 31, 2011, for free-standing clinics or May 31, 2011, for hospital-based clinics, with the cost reconciliation process completed no later than December 31, 2012.

If, at the end of the cost reconciliation, it is determined that the CMHC provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the CMHC provider will receive a lump sum payment upon discovery, but no later than 24-months of the end of the cost reporting period, in the amount of the underpayment.

10. DENTAL SERVICES

Fee Schedule. The definitions of dental and surgical procedures are based on the definitions of dental and surgical procedures given in the Current Dental Terminology (CDT).

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of physical therapy services. The agency's fee schedule rate was set as of September 1, 2019 and is effective for services provided on and after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

PHYSICAL THERAPY SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

A payment provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of physical therapy services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on and after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

11b. OCCUPATIONAL THERAPY SERVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

A payment provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.

patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of physical therapy services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

11c. SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent addition of Physician's Current Procedural Terminology (CPT).

A payment provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of speech, hearing and language disorder services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

12a. PRESCRIBED DRUGS

The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500-520 as amended.

a. Reimbursement for covered prescription and nonprescription drugs shall be the lowest of the following as of the date of dispensing:

(1) "Estimated acquisition cost (EAC)," defined as the average Actual Acquisition Cost (AAC), as determined from surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee. If no AAC is available, the EAC will be defined as the Wholesale Acquisition Cost (WAC), as published by Medi-Span.

(2) "Federal upper limit (FUL)," defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee.

(3) Submitted charge, representing the provider's usual and customary charge for the drug.

b. Professional Dispensing Fee: The professional dispensing fee is based on the cost of dispensing survey which must be completed by all medical assistance program participating pharmacies every two years beginning in 2014. For services rendered the professional dispensing fee is $10.07.

c. Subject to prior authorization requirements, if a physician certifies in the physician's handwriting that, in the physician's medical judgment, a specific brand is medically necessary for a particular recipient, the FUL does not apply and the payment equals the lesser of EAC or submitted charges. If a physician does not so certify, the payment for the product will be the lower of FUL, EAC, or submitted charges.

State/Territory: IOWA

(c). 340B Purchased Drugs - Reimbursement for a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), plus the professional dispensing fee pursuant to subsection (b).

(d). 340B Contract Pharmacies - Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

(e). Federal Supply Schedule (FSS) Drugs - Reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will the provider's actual acquisition cost (not to exceed the FSS price), plus the professional dispensing fee pursuant to subsection (b).

(f). Nominal Price Drugs - Reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR § 447.508 will be the provider's actual acquisition cost (not to exceed the Nominal Price), plus the professional dispensing fee pursuant to subsection (b).

(g). Reimbursement for Specialty Drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail pharmacy shall be the lowest of the following as of the date of dispensing:

1. "Actual Acquisition Cost" (AAC), defined as the average state AAC, as determined from biannual surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee pursuant to subsection (b). If no state AAC is available, the AAC will be defined as the Wholesale Acquisition Cost (WAC).

2. "Federal upper limit (FUL)," defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee pursuant to subsection (b).

3. Total submitted charge.

4. The provider's usual and customary charge to the general public.

State/Territory: IOWA

(j). Reimbursement for physician administered drugs submitted under the medical benefit is set by a Fee Schedule, based on Average Wholesale Price (AWP) of the drug less 15.6 percent, which is based on the following formula:

1. Average of the Average Wholesale Price (AWP) for the applicable National Drug Codes (NDCs) less 12 percent

2. Amount calculated in (1) less 5 percent

3. Amount calculated in (2) plus 1 percent

Reimbursement for covered entities using drugs purchased through the 340B drug pricing program at the 340B covered entity actual acquisition cost (AAC).

(k). Reimbursement is not provided for investigational drugs, which are not covered.

(l). An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by a pharmacist.

(m). Reimbursement for drugs provided by Indian Health providers is at the rate for outpatient medical care provided by IHS facilities that is published by IHS in the federal register each calendar year for Medicaid beneficiaries. Indian Health providers may bill for one covered outpatient prescribed drug visit per patient per calendar day for covered outpatient prescribed drugs provided by the facility, which shall constitute payment in full for all drugs provided on that day, including reimbursement for dispensing fees, ingredient cost, and any necessary counseling. For this purpose, Indian Health providers are pharmacies operated by the United States Indian Health Service (IHS) or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," or "tribal organization," as those terms are defined in 25 USC 1603.

Pharmacies and providers will submit information to the department or its designee within 30 days following a request for such information unless the department or its designee grants an extension upon written request of the pharmacy or provider. Pharmacies and providers are required to produce and submit information in the manner and format requested by the department or its designee, as requested, at no cost to the department or its designee.

12b. DENTURES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12c. PROSTHETIC DEVICES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12d. EYEGLASSES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES

For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1, 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

State/Territory: IOWA

13d. REHABILITATIVE SERVICES (Cont.)

For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in 2 CFR Part 200 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

Assertive Community Treatment (ACT) Services. ACT services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting. See Supplement 2, Attachment 3.1A, Page 31(b)(1-8) for a list of the specific services.

For ACT services, the unit of service is a client day. The services will be paid on a fee-for-service basis for each day that services are performed, including face-to-face contact with the client and conducting daily organization staff meetings to review the status of the team's clients and the scheduling of upcoming interventions. Providers cannot bill for a day during which no service was performed.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ACT services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published at http://dhs.iowa.gov/ime/providers/csrp/fee-schedule.

Revised Submission 8.23.11

State/Territory: IOWA

Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.

Revised Submission 8.23.11

State/Territory: IOWA

11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

For services provided prior to July 1, 2011, Rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary costs shall not exceed 110 percent of the statewide average allowable costs for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

14a. SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

See Attachment 4.19-A of the State Plan.

14b. SERVICES FOR INDIVIDUAL AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – NURSING FACILITY SERVICES

See Attachment 4.19-D of the State Plan.

15a. ICF/MR SERVICES – NOT PUBLIC

See Attachment 4.19-D of the State Plan.

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15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

16. INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 YEAR OF AGE

See Attachment 4.19-A of the State Plan.

17. NURSE-MIDWIFE SERVICES

When nurse midwife services are provided in a birthing center by a nurse-midwife employed by the center, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse mid-wives in birth centers, provided the nurse mid-wife is required to turn over his or her fees to the center as a condition of employment.

When nurse midwife services are provided in a birthing center by a nurse mid-wife with whom the nurse-midwife has a contract under which the facility submits the claim, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse midwives in birthing centers.

All other payments for the services of an nurse-midwife enrolled in the Iowa Medicaid program shall be paid on the basis of the fee schedule for services provided nurse mid-wives and no separate payment shall be made to any other facility or provider in connection with the birth, other than a hospital, or ambulatory surgical center. The nurse-midwife fee schedule is based on 85% of the physician fee schedule.

18. HOSPICE SERVICES

Iowa Medicaid reimburses for hospice services in accordance with the requirements of Section 4306 of the State Medicaid Manual (Hospice Reimbursement).

Pursuant to Section 4307 of the State Medicaid Manual (Payment for Physician Services Under Hospice), when the Iowa Medicaid agency has been notified of the name of the physician who has been designated as the attending physician and is not a hospice employee, the Iowa Medicaid Agency will reimburse the attending physician in accordance with the physician fee schedule described in Item 5a.

19a. CASE MANAGEMENT SERVICES

For Target Group 1 (Adults with chronic mental illness, and severely emotionally disturbed children receiving services through the HCBS Children's Mental Health waiver); and Target Group 2 (Persons with a developmental disability, including mental retardation):

For the period July 1, 2010, through June 30, 2018, reimbursement rates for case management providers will be established on the basis of a 15 minutes unit consistent with 2 CFR, part 200 as implemented by HHS at 45 CFR, Part 75. Case Management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency.

Interim Payment

The Department will make interim payments to Case Management providers based upon a projected cost report. Providers are required to submit a CMS-approved, Medicaid projected cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment.

Annual Cost Report Process

Case Management providers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after each fiscal year end. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Case Management.

The Medicaid cost report data includes direct costs, programmatic indirect costs, and general and administrative costs. Direct costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel and other direct costs related to the delivery of Case Management services. Programmatic indirect costs include salaries, benefits and other costs that are indirectly related to the delivery of Case Management services. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the Case Management service, constitute costs that support the operations of the Case Management agency. These general and administrative overhead cost was identified consistent with 2 CFR, part 200 as implemented by HHS at 45 CFR, Part 75. Case Management providers must eliminate unallowable expenses from the cost report. If they are not removed Iowa Medicaid will make the appropriate adjustments to the Case Management's Medicaid cost report.

Cost Reconciliation Process

The cost reconciliation must be completed within twenty-four (24) months of the end of the cost report period covered by the annual Medicaid cost report. The total Medicaid allowable costs per unit are compared to the interim projected rate paid for services delivered during the reporting period. Retroactive claim adjustments are made based on the final rates determined using the final actual financial reports.

Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The method of cost apportionment consistent with 2 CFR, part 200 as implemented by HHS at 45 CFR, Part 75, shall be used to determine the actual cost of services rendered to Medicaid recipients. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

State/Territory: IOWA

For Dates of Service on or after July 1, 2018
Case management services are reimbursed according to a fee schedule based on 15-minute units of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of case management for Target Group 1 and Target Group 2. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. All rates are published on the agency's website: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Target Group 3
For Target Group 3 (Children from birth to age three who meet the "developmental delay" eligibility categories set forth in the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA)):

Case management services are reimbursed according to a fee schedule based on 15-minute units of service. The number of 15-minute units billed cannot exceed 24 per day per case manager. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of case management for Target Group 3. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. All rates are published on the agency's website: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

19b RESERVED

20. EXTENDED SERVICES FOR PREGNANT WOMEN
Fee Schedule.

State/Territory: IOWA

21. AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN DURING A PRESUMPTIVE ELIGIBILITY PERIOD
Fee Schedule.

22. RESERVED

23. NURSE PRACTITIONER SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is based on 85% of the physician fee schedule.

24a. TRANSPORTATION SERVICES
Fee Schedule. If transportation is by car, the maximum payment that may be made is the actual charge made by the provider for transportation to and from the source of medical care, based on a fee schedule.

24b. RESERVED

24c. RESERVED

24d. SKILLED NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE
See Attachment 4.19-D of the State Plan.

24e. RESERVED

24f. RESERVED

25g. RESERVED

26. RESERVED

27. RESERVED

28. RESERVED

Revised Submission 6.27.13

State/Territory: IOWA

29. FREE-STANDING BIRTH CENTER SERVICES

Reimbursed based on a fee schedule as follows:
(a) Payment for covered services provided by a participating free-standing birth center is limited to the lesser of the charges billed or the allowable rates per fee schedule.
(b) The fee schedule established is based upon: (1) review of Medicaid fees paid by other states; (2) Medicaid fees for similar services; (3) Medicare fees; and/or (4) some combination or percentage thereof.

Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:
http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

29. **Payment Adjustment for Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(B)

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable conditions identifies below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

Medical claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (4) diagnoses codes on the claim.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Supplemental Payments for Physician and Professional Services at Qualifying Iowa State-Owned or Operated Professional Services Practices

1. Qualifying Criteria

Physicians and other eligible professional service practitioners as specified in 2. below who are employed by, or under contract to, or who assigned Iowa Medicaid payments to an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency programs recognized by the American College of Graduate Medical Education (ACGME) may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

a. licensed by the State of Iowa;
b. enrolled as a Iowa Medicaid provider; and,
c. identified by the Iowa state-owned hospital as a physician or professional service practitioner that is employed, under contract with, or provides services affiliated with the Iowa state-owned hospital.

Providers that qualify under this criterion are the following:

- The University of Iowa Hospitals and Clinics (UIHC)

2. Qualifying Providers Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

a. Physicians
b. Doctors of Dental Medicine
c. Doctors of Dental Surgery
d. Optometrists
e. Podiatrists
f. Physician Assistants;
g. Advanced Registered Nurse Practitioners (ARNPs);
h. Certified Registered Nurse Anesthetists (CRNAs);
i. Certified Nurse Midwives (CNMs);
j. Clinical Social Workers (CSWs);
k. Clinical Psychologists;
l. Clinical Nurse Specialists;
m. Anesthesiology Assistants;
n. Audiologists;
o. Genetic Counselors;
p. Licensed Mental Health Counselors;

q. Occupational Therapists;
r. Ocularists;
s. Pharmacists
t. Physical Therapists;
u. Registered Dietitians or Nutrition Professionals;
v. Respiratory Therapists; and
w. Speech-Language Pathologists

3. Methodology to Calculate the Average Commercial Rate

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate level is defined as the rates paid by commercial payers for the same service.

The specific methodology to be used in establishing the average commercial rate for qualifying providers is as follows:

a. Annually, the state will calculate a Medicaid to commercial conversion factor as follows:
   i. For services provided by qualifying providers at a hospital meeting the criteria as set forth in "1." above, the state will collect from the hospital its current commercial provider rates by CPT code for the hospital's top five commercial payers by volume.
   ii. The state will calculate the average commercial rate for each CPT code for each qualifying provider type, as defined under "2." above, that provides services at, under contract to, or in affiliation with the Iowa state-owned hospital.
   iii. The state will extract from its paid claims history file for the preceding fiscal year all paid claims based on dates of service for those qualifying provider types, as defined under "2." above, who will qualify for a supplemental payment. The state will align the average commercial rate for each CPT code as determined in "ii." above to each Medicaid claim for each qualifying provider type, as defined under "2." above and calculate the average commercial payments for the claims.

The state will then calculate an overall Medicaid to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicaid payments for the claims. Mid-level practitioner payment differentials, based on the previous years' overall average payment rate for mid-level providers, will be applied to this calculation.

State/Territory: IOWA

4. Methodology to Calculate the Supplemental Payment Amount
   a. For each quarter the state will extract Medicaid claims based on dates of service for each qualifying provider type, as defined under "2." above for that quarter.
   b. The Medicaid paid claims are then multiplied by the Medicaid to commercial conversion factor to establish what the payment amount would have been based on the average commercial rate.
   c. Total Medicaid paid claims are then subtracted from the payment amount based on the average commercial rate to identify the supplemental payment amount for qualifying providers for that quarter.

5. Effective Date of Payment
   The supplemental payment will be made effective for services provided on or after July 1, 2020.

State/Territory: IOWA

4. Methodology to Calculate the Supplemental Payment Amount
   a. For each quarter the state will extract Medicaid claims based on dates of service for each qualifying provider type, as defined under "2." above for that quarter.
   b. The Medicaid paid claims are then multiplied by the Medicaid to commercial conversion factor to establish what the payment amount would have been based on the average commercial rate.
   c. Total Medicaid paid claims are then subtracted from the payment amount based on the average commercial rate to identify the supplemental payment amount for qualifying providers for that quarter.

5. Effective Date of Payment
   The supplemental payment will be made effective for services provided on or after July 1, 2020.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

This program provides supplemental payments for eligible Ground Emergency Medical Transportation (GEMT) providers that meet specified requirements and provide GEMT services to Iowa Medicaid members.

Supplemental payments provided by this program are available only for the uncompensated and allowable direct and indirect costs incurred by eligible GEMT providers while providing GEMT services to Iowa Medicaid members. The supplemental payment covers the gap between the eligible GEMT provider's total allowable costs for providing GEMT services as reported on the GEMT services cost report and the amount of the base payment, mileage, and all other sources of reimbursement.

The supplemental payment amounts shall be calculated annually on a prospective basis after the conclusion of each state fiscal year (SFY). Payments shall not be paid as individual increases to current reimbursement rates as described in other parts of this state plan for GEMT services.

This supplemental payment applies only to Iowa Medicaid services rendered to Iowa Medicaid members by eligible GEMT providers on or after July 1, 2019.

A. Definitions

1. "Department" means the Iowa Department of Human Services.

2. "Direct Costs" means all costs that can be identified specifically with particular final cost objectives in order to meet all medical transportation mandates.

3. "Shared Direct Costs" are direct costs that can be allocated to two or more departmental functions or cost objectives on the basis of shared benefits.

4. "Indirect Costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using an agency approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with 2 C.F.R. Part 200 and CMS non-institutional reimbursement policy.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

5. "Eligible GEMT Provider" means a provider who is eligible to receive supplemental reimbursement because it meets all of the following requirements continuously during the claiming period:

    a. Provides Ground Emergency Medical Transportation services to Iowa Medicaid members.

    b. It is a provider that is enrolled as an Iowa Medicaid provider for the period being claimed.

    c. Is owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

6. "Dry Run" means a run that does not result in either a transport or a delivery on-site of Medicaid covered services.

7. "GEMT Transport" means GEMT services provided by eligible GEMT providers to individuals and does not, include dry runs as defined in Paragraph, A.6.

8. "GEMT Services" means both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advance, and basic life support services provided to an individual by GEMT providers before or during the act of transportation.

    a. "Advanced Life Support" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

b. "Limited-Advanced Life Support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services.

c. "Basic Life Support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

9. "Service Period" means the period from July 1 through June 30 of each SFY.

10. "Shift" means a standard period of time assigned for a complete cycle of work, as set by each eligible GEMT provider. The number of hours in a shift may vary by GEMT provider, but will be consistent to each GEMT provider.

B. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with Medicaid cost principles at 2 C.F.R. Part 200, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Iowa Medicaid program, except as expressly modified below.

2. Iowa Medicaid base payments to the GEMT providers for providing GEMT services are derived from the Ambulance provider fee schedule established for reimbursements payable by the Iowa Medicaid program by procedure code. The base payments for these eligible GEMT providers are fee-for-service (FFS) payments. The primary source of paid claims data and other Iowa Medicaid reimbursements is the Iowa Medicaid Management Information System (IA-MMIS). The number of paid Iowa Medicaid FFS GEMT transports is derived from and supported by the IA-MMIS reports for services during the applicable service period.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

3. The total uncompensated care costs of each eligible GEMT provider available to be reimbursed under this supplemental payment program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols (Section C.) for each eligible GEMT provider rendering GEMT services to Iowa Medicaid members net of the amounts received and payable from the Iowa Medicaid program and all other sources of reimbursement for GEMT services provided to Iowa Medicaid members. If the eligible GEMT providers do not have any uncompensated care costs, then the provider will not receive supplemental reimbursement under this supplemental payment program.

4. The Iowa Medicaid supplemental payment under this segment are the uncompensated care costs for GEMT services provided by eligible GEMT providers to Iowa Medicaid members as determined by the Prospective Supplemental Payment Amount (Section D.).

C. Cost Determination Protocols

1. An eligible GEMT provider's specific allowable cost per-GEMT transport rate will be calculated based on the provider's audited financial data reported on the GEMT services cost report. The per-GEMT transport cost rate will be the sum of actual allowable direct, shared direct, and indirect costs of providing GEMT services (**excluding cost associated with dry runs as defined in Paragraph A.6 and runs where a Medicaid covered service was delivered but no transport occurred**) divided by the actual number of GEMT transports (including dry runs as defined in Paragraph A.6 **and runs where a Medicaid covered service was delivered but no transport occurred**) provided for the applicable service period.

    a. Direct costs for providing GEMT services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing GEMT services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policies and are directly attributable to the provision of the GEMT services.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

b. Shared direct costs for GEMT services must be allocated for personnel, capital outlay and other costs; such as medical supplies, professional and contracted services, training and travel. The personnel costs will be allocated based on a percentage of total hours logged performing GEMT services activities versus other service activities. The capital and other shared direct costs will be allocated based on the percentage of total call volume.

c. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Paragraph C.1.a) or derived from provider's approved cost allocation plan. Eligible GEMT providers that do not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with Medicaid cost principles specified at 2 C.F.R. Part 200.

d. The GEMT provider specific per-GEMT transport cost rate is calculated by dividing the total net GEMT services allowable costs (Paragraph C.1.a, C.1.b, and C.1.c) of the specific provider by the total number of GEMT transports provided by the provider for the applicable service period.

D. Prospective Supplemental Payment Amount

1. The Department will calculate annual prospective supplemental payment amounts for eligible GEMT provider on a per-GEMT transport basis. The per-GEMT transport prospective supplemental payment amount for each provider is based on the provider's completed annual cost report in the format prescribed by the Department for the applicable cost reporting year. The Department will make adjustments to the as-filed cost report based on the results of the most recently retrieved IA-MMIS report.

2. Each eligible GEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section C.) and must submit the completed annual as-filed cost report, to the Department five (5) months after the close of the service period.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

3. The prospective supplemental payment amount is calculated by subtracting from Iowa Medicaid's portion of the total GEMT allowable costs (Paragraph C.1) from the as-filed cost report adjusted by the Department (Paragraph D.1), the total Iowa Medicaid base payments (Paragraph B.2) and other payments, such as Iowa Medicaid co-payments, received by the providers for providing GEMT services to Iowa Medicaid members. The result of this calculation is the uncompensated care costs for GEMT services provided to Iowa Medicaid members.

4. The result in Paragraph D.3 is divided by the Iowa Medicaid GEMT transports (including dry runs as defined in Paragraph A.6) from the as-filed cost report adjusted by the Department to calculate the per-GEMT services prospective supplemental payment amount. This amount will be paid prospectively, in addition to the Iowa Medicaid base payments (Paragraph B.2) on a claim by claim basis.

5. The prospective supplemental payment amount will be updated the following July 1, and every year thereafter, following submission and review of the cost report. Specifically, the prior year's uncompensated care amount per Medicaid transport will be paid as an adjustment to the following year's base rate.

E. Eligible GEMT Provider Reporting Requirements

Eligible GEMT providers shall:

1. Submit the GEMT services cost report no later than five (5) months after the close of the CY, unless a provider has made a written request for an extension and such request is granted by the Department.

2. Provide supporting documentation to serve as evidence supporting information on the submitted cost report and the cost determination as specified by the Department.

3. Keep, maintain, and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible government entity is entitled, and any other records required by CMS.

Supplemental payment for publicly owned or operated ground emergency medical transportation providers

4. Comply with the allowable cost requirements provided in 2 C.F.R. Part 200, and Medicaid non-institutional reimbursement policy.

F. Department Responsibilities

1. The Department will submit to CMS claims for GEMT services that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.

2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.

3. The Department may conduct on-site audits as necessary and will complete the audit within two years of the postmark date of the accepted cost report.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☑	HCBS Case Management
	Providers of case management services shall be reimbursed at cost. Providers are reimbursed throughout each fiscal year on the basis of a projected interim payment rate for a 15-minute unit of service based on each provider's reasonable and proper costs of operation. Reasonable and proper costs of operation are identified pursuant to federally accepted reimbursement principles (OMB A-87 principles). The methodology for determining the reasonable and proper cost for service provision assumes the following: • The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation. • Mileage shall be reimbursed at a rate no greater than the state employee rate. • Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A). Interim payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664., Financial and Statistical Report submitted by providers ninety days after each fiscal year end. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost apportionment. For dates of services on or after July 1, 2018, HCBS case management services shall be reimbursed by fee schedule.
☑	HCBS Home-Based Habilitation
	For services provided on July 1, 2013 through December 31, 2013, home-based habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

☑	HCBS Day Habilitation
	For services provided on July 1, 2013 through December 31, 2013, day habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. The rates for Day habilitation are located at 441 IAC 79.1(2) https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf
☐	HCBS Behavioral Habilitation
☐	HCBS Educational Services
☑	HCBS Prevocational Habilitation
	For services provided on July 1, 2013 through December 31, 2013, prevocational habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule
☑	HCBS Supported Employment Habilitation
	For services provided on July 1, 2013 through December 31, 2013, supported employment habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fee schedule rate was set as of July 1, 2013 and is effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of supported employment habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

	Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one):*

◉	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be _____ days (not to exceed 60 days).

		Reimbursement for Supported Employment activities to obtain a job – job development, and supported employment activities to obtain a job – employer development is based on a fee schedule developed by the state Medicaid agency with advice and consultation from the appropriate professional group and reflects the amount of resources involved in service provision. Reimbursement for all other Supported Employment activities is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
☐	Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one)*:

◉	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be [ ] days (not to exceed 60 days).

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

IA-12-004

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Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Health Home Provider

Description

Overview of Payment Structure:
Iowa has developed the following payment structure for designated Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Iowa. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Patient Management Per Member Per Month Payment
This reimbursement model is designed to only fund Health Home services that are not covered by any of the currently available Medicaid funding mechanisms. Health Home Services, as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes. Iowa Medicaid Enterprise recognizes that health home transformation requires financial support to clinic leadership and administrative functions so that members receive services in a data driven, population focused, and person centered environment. The criteria required to receive a monthly PMPM payment is:
A. The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR).
B. The member has full Medicaid benefits at the time the PMPM payment is made.
C. The member has agreed and enrolled with the designated health home provider.
D. The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
E. The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring

for treatment gaps defined as Health Home Services in this State Plan, or a covered service defined in this state plan was provided that was documented in the member's EHR.
a. The health home will attest, by a monthly claim submission, that the minimum service requirement is met. The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of claim submission.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Tier Minutes Per Month Sum of Chronic Conditions
Tier 1 15 1-3
Tier 2 30 4-6
Tier 3 60 7-9
Tier 4 90 10 or more

Additional Tiering Information
Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

Reimbursement for Evaluation and Management (E/M) procedure code 99215 as of January 2012 was used as the base value for determining one hour of physician work. The count of major conditions serves as a proxy for the time (expressed in minutes in above table) and work required to coordinate patient care. PMPM time units of care coordination were determined for each tier utilizing best practice criteria for care coordination. The work of care coordination is divided between the physician and other members of the care coordination team; therefore, the following distribution of work in an optimally-functioning practice is as follows:
20% Physician
30% Care Coordinator
20% Health Coach
30% Office/Clerical

The fee-for-service rate for one hour of care coordination was calculated after discounting for the above work distribution over time (Care Coordinator and Health Coach are at 65% of the physician rate and office/clerical are at 30%).

The agencies rates were set as of July 1, 2012 and are effective for services on or after that date. All rates are published on the agency website: www.ime.state.ia.us/Reports_Publications/FeeSchedule.html . The State fully intends to evaluate set rates annually to ensure they are reasonable and appropriate for the services they purchase.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Quality/Outcome Measurement Incentive Calculation
All Health Home Providers will report annually Quality/Outcome Measurements to the State and are eligible to receive incentive payments for achieving quality/performance benchmarks. No monetary value will be tied to performance measures in the first measurement year, (7/1/2012 – 6/30/2013). Beginning July 1, 2013, performance payments will be paid lump sum annually based on achieving quality/performance benchmarks. The quality/outcome measures are separated into five categories: 1) Preventive Measures; 2) Diabetes Measures; 3) Hypertension Measure; and 4) Mental Health Measure; and 5) Total Cost of Care. Each category is weighted based on importance and attainability of the measures. Payment will be made by September 30, following the end of the perforamnce year.

The quality/outcome measurement incentive payment is equal to a percentage of the PMPM payments that are made to each participating health home. The maximum amount of incentive payment that a health home can attained is twenty (20) percent of the total PMPM payments made to that participating Health Home. The total PMPM payments is the sum of all Patient Management Payments make to the participating Health Home for patients attributed to the provider during the performance year.

The quality/outcome measurement incentive payment is contingent on a participating Health Home provider's performance on the quality/outcome measures specified for the categories below. Each category is worth a percentage of the maximum incentive payment amount. Within each category, the specified minimum performance must be achieved for each measure in order to receive the category's percent value; if performance is not achieved, on any of the required measures, the category's value is zero (0). The weight for each category achieved is then applied as a percentage of the maximum incentive payment amount.

The State will inform Health Home providers prior to the start of each performance year the target performance (also known as the minimum performance or benchmark) for each measure. The Health Home Provider must achieve the target performance for each measure in the category to achieve the bonus for that category.

Formula:
20% of Patient Management Payments for Measurement Year = Maximum Incentive Payment (MIP)
Category 1 Assigned Value = 35% of MIP
Category 2 Assigned Value = 30% of MIP
Category 3 Assigned Value = 20% of MIP
Category 4 Assigned Value = 15% of MIP

Category: Preventive Measures (best two out of three measures count for the practice)
Assigned Value of bonus = 35% Source = Health Information Network

Children turning 2 years old in reporting year who receive 4 DtaP, 3 IPV, 1 MMR, 4 HIB, 3 HEP-B, 1 VZV and 4 pneumococcal conjugate vaccines on or before their second birthday.

Flu shots for adults ages > 6 months
Document BMI and appropriate follow-up planning when needed.

Category: Disease Option 1 (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus = 30% Source = Health Information Network

Diabetes Management:
- Dilated eye exam (annual by optometrist or ophthalmologist)
- Micro albumin (annual)
- Foot exam (annual)
- Proportion with HgA1c less than 8
- Proportion with LDL less than 100

Asthma Management
- Asthma Patients with Asthma-related Emergency Room Visit
- Use of appropriate medications for people with asthma
- Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen

Category: Disease Option2 (Health Home picks the measure that most aligns with the practice population)
Assigned value of bonus = 20% Source = Health Information Network

Proportion with blood pressure less than 140 systolic and less than 90 diastolic; blood pressure check each visit.

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Systemic Antimicrobials

Category: Mental Health Measure (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus 15% Source = Health Information Network

Percentage of discharges for members 6 years of age and older who were hospitalized for treatment selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
Clinical Depression Screening

Category: Total Cost of Care
Assigned Value of Bonus = 0% Source = Health Information Network

Total cost of care per member/per year Reporting Only The state envisions this measures being tied to monetary bonus in the future, once the baseline has been established. This measure will begin for reporting purposes only to introduce the calculation to health home providers.

Health Home providers are measured during the twelve month reporting period using the measures described above for only those Health Home patients that were enrolled at start of the reporting period and that received at least two months of patient management payments during the reporting period.

☑ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

none

Description

none

☐ Tiered?

Continuation of Medicaid Payments Established by Section 1202 of the Affordable Care Act (Increased Primary Care Service Payment 42 CFR 447.400, 447.405, 447.410)

Attachment 4.19-B: Physician Services Amount of Minimum Payment

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 CFR 447.400, 447.405 and 447.410 remain in effect. The rates will be those in effect for these payments as of January 1, 2014.

☒ The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99339, 99340, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99403, 99404, 99406, 99411, 99412, 99429

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460 (Effective 01.01.11) , 90461 (Effective 01.01.11), 99224 (01.01.11), 99225 (01.01.11), 99226 (01.01.11), 99441 (10.01.10), 99442 (10.01.10), 99443 (10.01.10), 99444 (10.01.10), 99499 (10.01.10)

Physician Services – Vaccine Administration

The state reimburses vaccine administration services furnished by the physicians identified above at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the rate established in accordance with 42 CFR 444.405(b)(2) as of January 1, 2014.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered January 1, 2015 through June 30, 2017.

Vaccine Administration
This reimbursement methodology applies to services delivered January 1, 2015 through June 30, 2017.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness). The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date. All rates are published at http://dhs.iowa.gov/ime/providers/csrp/fee-schedule/agreement

Reserved